

Rev. 5-17-39
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28020
Registration District No. 185 Primary Registration District No. 2259 Registrar's No. _____

FILED SEP 12 1947

1. PLACE OF DEATH:
(a) County Christian
(b) City or town Rossville Rural Lind
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 50 yrs 1 years, months or days) (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Christian
(c) City or town Rossville Mo
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

3. (a) PRINT FULL NAME Nehemiah Bloomer
(b) If veteran, name war _____ (c) Social Security No. _____
(d) Sex Male (e) Color or race W
(f) (a) Single, widowed, married, divorced Widowed
(g) (b) Name of husband or wife _____ (c) Age of husband or wife if
alive _____ years
(h) Birth date of deceased Dec 6 1860
(Month) (Day) (Year)

4. AGE: Years 80 Months 7 Days 4 If less than one day
hr. _____ min. _____

5. Birthplace Missouri
(City, town, or county) (State or foreign country)

6. Usual occupation Farmer

7. Industry or business

8. MOTHER FATHER
(a) Name James Bloomer
(b) Birthplace Missouri
(City, town, or county) (State or foreign country)
(c) Maiden name Elveth Knowl
(d) Birthplace Missouri
(City, town, or county) (State or foreign country)

9. (a) Informant's own signature Jim Bloomer
(b) Address Rossville Mo, RR.
(c) Place: burial or cremation Buried
(d) Date thereof July 12-47
(Month) (Day) (Year)
(e) Signature of funeral director T. B. Chaffin
(f) Address Osark Mo
(g) (a) 8-9-41 (b) Josephine Murriet
(Date received local registrar) (Registrar's signature)

10. MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 10
year 1941 hour 7 1/2 minute 10 P. M.
21. I hereby certify that I attended the deceased from May 1
_____, 1941, to July 10, 1941
that I last saw him alive on July 10, 1941
and that death occurred on the date and hour stated above.
Immediate cause of death General Carcinoma
Primary lesion
Due to in stomach
Due to _____
Other conditions (include pregnancy within 3 months of death) H6B
Major findings: Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature W. A. Decker (M. D. or other)
Address Springfield Date signed _____
Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 6,

District File Number 941-1481

Date Filed SEP 10 1941

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed T. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Ogark Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.